Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JESSE O SCHNERINGER
1422 N LOOP 336 WEST STE C
CONROE TX 77304

Respondent Name
Liberty Insurance Corp

Carrier's Austin Representative
Box Number 01

MFDR Tracking Number
M4-13-3361-01

MFDR Date Received
August 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The 98943 code was not paid according to Medicare Fee Guidelines."

Amount in Dispute: $765.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly."

Response Submitted by: Liberty Insurance Corp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 12 – December 5, 2012	Chiropractic Services	$765.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by a health care provider.
3. 28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional services.

The services in dispute were reduced/denied by the respondent with the following reason codes:

- B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED.

Issues

1. Did the requestor correctly code the service in dispute?

2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(c) states "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." According to the documentation submitted, the service in dispute is a professional service described as, "Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions. This service may be found in the evaluation and management section of the American Medical Association (AMA), Current Procedural Terminology (CPT) code set. This service was billed by the requestor under CPT code 98943. The applicable division fee guideline is 28 Texas Administrative Code §134.203 Titled *Medical Fee Guideline for Professional Services*. The carrier denied payment as B291 – "THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED". 28 Texas Administrative Code §134.203 (b) (1) states, in pertinent part, that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing;…in effect on the date a service is provided with any additions or exceptions in the rules." Section 134.203(a)(5) defines "Medicare payment policy" to mean reimbursement methodologies, models, and values weights including its coding, billing and reporting payment policies as set forth in the Centers for Medicare and Medicaid services (CMS) payment policies specific to Medicare.

   The Medicare policy applicable to the disputed service can be found at MLN Matters® Number: SE1101 dated September 9, 2011 "98943: CMT, extraspinal, one or more regions, is not covered by Medicare."
   The division concludes that the in accordance with the applicable Medicare policy in effect on the date the service in dispute was provided, no additional payment can be recommended.

2. For the reasons stated above, the services in dispute are not eligible for payment pursuant to 28 TAC §134.203(a)(5).

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.